DCH/LPD-020 (05/04)

Michigan Department of Community Health
Board of Podiatric Medicine & Surgery
P.O. Box 30670
Lansing, Michigan 48909
(517) 335-0918

PODIATRY LICENSURE INSTRUCTIONS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Board of Podiatric Medicine and Surgery. Questions regarding your application can be directed to the Michigan Board of Podiatric Medicine and Surgery at (517) 335-0918 three weeks after the date you sent the application. Please allow 4-6 weeks processing time.

INSTRUCTIONS FOR FULL LICENSURE BY EXAMINATION

1. Complete the licensure applications for Podiatry and controlled substances and submit them along with the appropriate fees to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Have your school submit a final, official transcript that shows the date your DPM was conferred directly to the Board office. If a final transcript is not available by the Part III examination registration deadline date, an official letter must be submitted from the Registrar or Dean of your school indicating the date you will receive your degree. You must graduate prior to taking the examination. The final, official transcript must be received directly from your school before your license will be issued.

3. You will be made eligible to sit for the Part III examination upon receipt of #1 and #2 above.

4. Submit proof of completion of one year of training in an approved preceptorship or residency program. The Preceptor or Director of that program should submit the *Certification of Residency Training or Preceptorship* form directly to this office after completion.

5. Contact the Chauncey Group ((877) 302-8952 or e-mail JAntal@Chauncey.com) to receive a request form to have National Board exam scores for Part I and Part II sent directly to this office.

6. If you took Part III in another state, contact the Federation of Podiatric Medical Boards ((561) 752-3735 or www.fpmb.org) to have those scores sent directly to this office.

7. Once the Board office receives your application, a jurisprudence examination will be mailed to you. You must complete the examination and return it to the Board office at the above address.

8. Each state in which you hold or have ever held a permanent podiatry license must submit verification of licensure directly to the Board office. The attached Verification of Licensure Form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

INSTRUCTIONS FOR FULL LICENSURE BY ENDORSEMENT

1. Complete the licensure applications for Podiatry and controlled substances and submit them along with the appropriate fees to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Have your school submit a final, official transcript of your podiatric education directly to the Board office.

3. Each state in which you hold or have ever held a permanent podiatry license must submit verification of licensure directly to the Board office. The attached Verification of Licensure Form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. Applicants who graduated from a school of podiatric medicine after December 31, 1964, must submit proof of completion of one year of training in an approved preceptorship or residency program. The Preceptor or Director of that program should submit the *Certification of Residency Training or Preceptorship* form directly to this office after completion.

6. An applicant who was first licensed in another state on or after January 1, 1980, is required to have taken and passed Part I and Part II of the National Board examination. Contact the Chauncey Group ((877) 302-8952 or e-mail JAntal@Chauncey.com) to receive a request form to have those scores sent directly to this office.

7. Applicants who were licensed in another state less than three years before filing an application for Michigan licensure need to send in passing scores for Part III (PMLexis) and pass the Michigan Jurisprudence examination. If you have previously taken Part III (PMLexis), contact the Federation of Podiatric Medical Boards ((561) 752-3735 or www.fpmb.org) to have those scores sent directly to this office. Once the Board office has received your application, a jurisprudence examination will be mailed to you. You must complete the examination and return it to the Board office at the above address.

EDUCATIONAL LIMITED LICENSE APPLICANTS

POST GRADUATE INTERNSHIP TRAINING IN MICHIGAN SHALL NOT BEGIN UNTIL YOU HOLD AN EDUCATIONAL LIMITED LICENSE. NO CREDIT CAN BE APPROVED FOR TRAINING OBTAINED BEFORE THE ISSUE DATE OF THE LIMITED LICENSE.

1. Complete the application and submit it along with the fee to the Board office. An application accompanied by the appropriate fee is valid for two years. If an applicant fails to complete the requirements for licensure within two years from the date of filing the application, the application is no longer valid.

2. Have your school submit a final, official transcript that shows the date your DPM was conferred directly to the Board office.

3. Each state in which you hold or have ever held a permanent podiatry license must submit verification of licensure directly to the Board office. The attached Verification of Licensure Form may be duplicated. You may wish to check with the other state(s) as a fee is usually charged for this service.

4. Contact the Chauncey Group ((877) 302-8952 or e-mail JAntal@Chauncey.com) to receive a request form to have National Board Part I and II scores sent directly to this office. **OR** have the Federation of Podiatric Medical Boards (PO Box 740525, Boynton Beach, FL 33474-0525, (561) 477-3060) send your passing Part III (PMLexis) scores directly to this office.

5. Have the Director of the program submit the *Certification of Appointment to a Hospital Training Program* form (attached) or the Preceptor submit an *Application for Approval of a Preceptorship Program* form. The form for approval of a preceptorship program can be obtained by sending an e-mail request to bhphelp@michigan.gov. The preceptorship must be approved by the Board before the limited license can be issued. A person who is issued an educational limited license must confine his or her practice and training to the approved site for training. In the event of a change in appointment, the limited licensee is required to seek approval from the Board before the change occurs. An educational limited license may be renewed 5 times, with no extension available.

6. Upon completion of the preceptorship or residency, the limited licensee must have the Preceptor or Director of the program submit the *Certification of Residency Training or Preceptorship* form.

NOTE: Educational limited licensees or applicants for educational limited licensure are not eligible to take the PMLexis and jurisprudence examinations until they have applied for full licensure.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Board of Podiatric Medicine and Surgery in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes.

2. REFUND POLICY: If you wish to withdraw your application, you may be eligible for a partial refund. You must notify the Board of Podiatric Medicine and Surgery in writing to request a refund.

ORIGINAL FULL LICENSES ARE VALID FOR ONE YEAR OR LESS; SUBSEQUENT RENEWALS ARE FOR A THREE-YEAR PERIOD.

Michigan Department of Community Health
Board of Podiatric Medicine and Surgery
P.O. Box 30670
Lansing, MI 48909
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APPLICATION FOR LICENSURE AS A PODIATRIST

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Board Use Only
License Number
Date of Licensure

Type or Print Only

I AM APPLYING FOR THE FOLLOWING:

- ☐ **License by Examination Fee: $120.00 71-5901-01**
- ☐ **License by Endorsement Fee: $120.00 71-5901-09**
- ☐ **Educational Limited License Fee: $50.00 71-5901-03**

Your check or money order drawn on a U.S. financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH.** Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

U.S. Social Security Number	Date of Birth	Michigan Permanent I.D. Number and Expiration Date

Street Address		

City	State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Have you ever held a health professional license in Michigan?

☐ No ☐ Yes

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. **Have you ever been convicted of a felony?**	☐ Yes	☐ No
2. **Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum term of 2 years?**	☐ Yes	☐ No
3. **Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?**	☐ Yes	☐ No
4. **Have you been treated for substance abuse in the past 2 years?**	☐ Yes	☐ No
5. **Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?**	☐ Yes	☐ No
6. **Have you had one or more settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?**	☐ Yes	☐ No
7. **Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?**	☐ Yes	☐ No

Name

8. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privileges involuntarily modified? ☐ Yes ☐ No

9. Do you hold or have you held a permanent podiatry license or registration in any state? If yes, list each state, the license or registration number, the date issued, and how the license was obtained (either endorsement or examination). DO NOT LIST TEMPORARY LICENSES. You must have each state board verify licensure directly to this board office. (Attach additional sheets if necessary.) ☐ Yes ☐ No

State	License/Registration Number	Date of Issue	How obtained (Endorsement or examination)

Provide a complete chronological record of your podiatric education. Attach additional sheets if necessary.

Name and address of Institution	Dates of Attendance From	To	Degree

RESIDENCY/PRECEPTORSHIP INFORMATION (Either completed, current or planned)

Name of Hospital	Location	Dates of Attendance From	To

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Podiatric Medicine and Surgery
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918

CERTIFICATION OF APPOINTMENT TO A HOSPITAL TRAINING PROGRAM

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, certification will not be issued.

SECTION I - APPLICANT INFORMATION

INSTRUCTIONS: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the Program Director of the Michigan hospital where you have been appointed for completion of Section II.

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Street Address

City

State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Names Used (if applicable)

Signature of Applicant	Date

Applicant: Upon completion of Section I, send this form to the Program Director for completion of Section II.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR

SECTION II - CERTIFICATION OF RESIDENCY APPOINTMENT

Please complete the following information. Return this completed certification directly to the Michigan Board of Podiatric Medicine and Surgery at the address shown on the page 1 of this form.

Name of Hospital

Street Address of Hospital

City, State and ZIP Code

I certify that _____
(Applicant's Name)

has been appointed to a podiatric residency at the hospital named above beginning _____
(Month/Day/Year)

and ending _____.
(Month/Day/Year)

Is this training program approved by the CPME (Council on Podiatric Medical Education)? ☐ **Yes** ☐ **No**

_____ _____
Authorized Signature Date of Signature

_____ **(S E A L)**
Print or Type Name

_____ **If hospital has no seal, please indicate**
Title

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.

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CERTIFICATION OF RESIDENCY TRAINING OR PRECEPTORSHIP

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

SECTION I - APPLICANT INFORMATION

Instructions: Complete Section I. Type or print your name exactly as it appears on your application. Send this form to the Preceptor or Program Director when you complete your training. This form should be completed and returned directly to the Board office by the Preceptor or Program Director.

First Name	Middle Name	Last Name

Social Security Number	Date of Birth

Street Address

City

State	ZIP Code

Daytime Telephone Number	All Previous Names and/or Birth Name Used (if applicable)

Signature of Applicant	Date

Applicant: Upon completion of Section I, send this form to the Preceptor or Program Director for completion of Section II.

Name

THIS SIDE TO BE COMPLETED BY THE PROGRAM DIRECTOR OR PRECEPTOR

SECTION II - CERTIFICATION OF RESIDENCY/PRECEPTORSHIP

Please complete the following information. Return this completed certification directly to the Michigan Board of Podiatric Medicine and Surgery at the address shown on page 1 of this form.

Name of Training Hospital or Preceptor

Street Address

City, State and ZIP Code

I certify that _____ **has successfully**
(Applicant's Name)

completed a residency or preceptorship, offered by the above from _____ **to**
(Month/Day/Year)

_____ .
(Month/Day/Year)

If the training was completed in a hospital, was the program accredited by the CPME (Council on Podiatric Medical Education)?

☐ **Yes** ☐ **No**

_____ _____
Signature of Program Director or Preceptor Date of Signature

_____
Print or Type Name of Program Director or Preceptor

(S E A L)

If school has no seal, please indicate

NOTE: Certification of training will not be accepted if certified more than 15 days prior to actual completion.

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (01/05)

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Board Use Only
Date of Licensure
License Number

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: **Initial (first time) professional license or relicensure of your professional license - $85.00. If you already hold a professional license and your professional license expires in:**

0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

THIS LICENSE VALID - ONLY AT THE FOLLOWING LOCATION

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educational Limited
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐
☐ 43 - 01 M.D. 71-5315	☐		
☐ 51 - 01 D.O. 71-5315	☐		
☐ 49 - 01 O.D. 71-5330	☐		
☐ 53 - 01 Pharmacy Store 71-5301	☐		
☐ 53 - 02 R.Ph. 71-5302	☐		
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐		

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**

☐ **Yes** ☐ **No**

If Yes, please explain on separate sheet.

2. **Is your current professional license limited as a result of Board disciplinary action?**

☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

OHS/HLD-001 (01/04)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, MI 48909

VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

- ☐ Chiropractic
- ☐ Counseling
- ☐ Dentistry
- ☐ Marriage & Family Therapy
- ☐ Medicine
- ☐ Nursing
- ☐ Nursing Home Adm.
- ☐ Occupational Therapy
- ☐ Optometry
- ☐ Osteopathy
- ☐ Pharmacy
- ☐ Physical Therapy
- ☐ Physician's Assistants
- ☐ Podiatry
- ☐ Psychology
- ☐ Sanitarians
- ☐ Social Work
- ☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Basis for Issuance of License:
☐ Examination - Please indicate type of exam (National, Regional, State, etc.)
☐ Endorsement - Please indicate name of state

Type of License:

License Status	Original Issue Date	Expiration Date
☐ Current ☐ Lapsed ☐ Inactive		

Has the applicant incurred any formal or informal actions in your State?
☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.